Adult High-Tech Nursing Program
REFERRAL FORM

Directions: A Medical Provider (MD, NP, or PA) must complete this **ENTIRE** form and fax it to:
802-241-0385 Attn: Adult High-Tech Program
Questions? Call (802)241-0294 or e-mail: mary.woods@vermont.gov
You are encouraged to attach additional clinical information. You may be contacted if more information is needed.

PROGRAM ELIGIBILITY CRITERIA – The client must meet all of the below:

☐Have Vermont Medicaid,
☐Be a Vermont resident residing in-state,
☐Be greater than 21 years old,
☐Require more individual and continuous skilled nursing care than can be provided in a skilled nurse visit,
☐Require care outside the scope of services provided by a Home Health Aid/PCA, and
☐Have at least two caregivers available to provide care at home who are able to accommodate the necessary medical equipment and personnel needed to safely care for the adult.

CLIENT'S INFORMATION

Full Name			Guardian Name(s)	
Diagnosis			ICD-10 Code	Date of Diagnosis
Gender ☐ M ☐ F	Age	Date of Birth	Medicaid ID No.	Interpreter Needed? ☐Yes ☐No Language:
Home Address				
City	State **VT**	Zip	Phone	
Mailing Address, if different				

REFERRING PROVIDER INFORMATION

Full Name	Medicaid Provider#	Practice Care Coordinator Name
Practice Name & Address		
City	State / Zip	Phone

LEVEL OF CARE – The following information does not guarantee services.

Which of the following characterizes this client's risk for hospitalization:
- ☐Currently hospitalized
- ☐ Little or no risk of hospitalization
- ☐Multiple hospitalizations in the past 12 months (2 or more inpatient admissions)
- ☐Increased risk due to chronic fragile state

Which description best fits this client's overall status? This client is…
- ☐Stable with no heightened risk(s) for serious complication and death
- ☐Temporarily facing high health risks but is likely to return to being stable without heightened risk(s) for serious complications and death
- ☐Likely to remain in fragile health and have ongoing high risk(s) of serious complications and death

Needs: ☐mechanical ventilation ☐airway clearance ☐IV administration ☐observation and intervention
Anticipated Duration: ☐<3 months ☐3-6 months ☐6-12 months ☐>12 months
Equipment: ☐mechanical ventilator ☐PICC/central line ☐peripheral line ☐enteral tube ☐suction

MD/NP/PA Signature	Date	FOR ASD USE ONLY Date Received Initials